LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS
ELDER'S DENTAL PROGRAM APPLICATION

Email: PRCfax@ltbbodawa-nsn.gov
Fax: 231-242-1617

Elder's Living Outside the 27-County Service Area

I, _____ , have reviewed the following:
PLEASE PRINT YOUR FULL NAME

- The Elder's Dental Program can only be accessed **one (1) time** within the current calendar year.
- Since the Elders resides outside the LTBB 27-county service area, they may utilize a dental provider of their choice and will be eligible for a maximum benefit of $2,400 per calendar year.
  - IMPORTANT NOTE: The Elder **must** discuss with their provider about receiving payment from the Elder's Dental Program. If they do not accept payment from the program, the Elder **will be responsible** for all payments, and the program will reimburse them upon proof of payment to the dentist
- A **Treatment Plan** from the dentist must be submitted with the application
- Anything deemed cosmetic in nature **will not** be covered by the program. This includes, but is not limited to, dental implants, orthodontics, and specialty coatings.
- The Elder's Dental Program is considered the PAYER OF LAST RESORT. This means **all** dental/medical insurance **must be billed prior** to the Elder's Dental Program issueing payment.
- The Elder is responsible for completing and submitting this application in **its entirety** including submitting their *Tribal ID, any dental insurance information, the treatment plan, and the Release of Information Agreement*

I UNDERSTAND THAT FAILURE TO FOLLOW THESE INSTRUCTIONS WILL RESULT IN MY APPLICATION BEING DENIED. I ALSO UNDERSTAND IF I PROVIDE FALSE INFORMATION CAN RESULT IN REFERRAL TO THE PROSECUTING ATTORNEY FOR FRAUD, AND/OR RECOVERY OF FUNDS PAID ON MY BEHALF.

☐ **I AM CHOOSING TO BE REIMBURSED BY THE PROGRAM**

☐ **THE DENTAL PROVIDER HAS AGREED TO ACCEPT PAYMENT FROM THE PROGRAM**

_____ **SIGNATURE AND DATE**

_____ **DATE OF BIRTH**

_____ **MAILING ADDRESS**

_____ **TRIBAL ID #**

_____ **CITY/STATE/ZIP**

_____ **PHONE #**

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Release of Information Agreement

PLEASE PRINT YOUR FULL NAME _____ DATE OF BIRTH _____

MAIDEN NAME (IF APPLICABLE) _____ TRIBAL ID # _____

ADDRESS _____ PHONE # _____

PO BOX _____ TRIBAL ID # _____

CITY/STATE/ZIP _____ PHONE # _____

I HEREBY AUTHORIZE MY CONFIDENTIAL DENTAL INFORMATION TO BE RELEASED FROM THE OFFICES THAT HOLD INFORMATION REGARDING ANY CARE AND/OR TO REALEASE ANY CONFIDENTIAL INFORMATION BETWEEN THE LTBB HEALTH DEPARTMENT LISTED IN THIS AGREEMENT.

SIGNATURE _____ DATE _____

AGENCIES RELEASING INFORMATION TO EACH OTHER:

Little Traverse Bay Bands of Odawa Indians
Health Department
1260 Ajijaak Avenue
Petoskey, MI 49770

AND

Elder's Dental Program
P:231-242-1600
F:231-242-1617

Dental Provider Information:

_____
_____
_____
_____
_____

Dental Insurance Information:

_____
_____
_____
_____
_____

FOR OFFICE USE ONLY | LEAVE BLANK

Documentation Checklist

- ☐ Did the patient submit a completed application?
- ☐ Did the patient submit a Treatment Plan?
- ☐ Did the patient submit a copy of their Tribal ID?
- ☐ Does the patient have any dental insurance?
- ☐ Did the patient complete the Release of Information Agreement?

YES/NO Has the patient already utilized the Elder's Dental Program within the calendar year?

Notes:

_____

_____

_____

_____

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_____

_____

_____

☐ APPROVED ☐ DENIED

_____ _____

APPROVAL'S SIGNATURE **DATE**

_____

APPROVAL'S PRINTED NAME AND POSITION TITLE

FOR OFFICE USE ONLY | LEAVE BLANK

What happens next?

#1 The application is submitted to the Health Services Navigator (HSN) for review.

#2 The HSN will review the application, treatment plan, and all other supporting documents.

#3 A letter will be submitted to the patient with the determination of coverage.

If **approved**, the patient may now coordinate with their doctor and schedule appointments for the services.

If **denied**, and the patient disagrees with the determination, then they may submit a ***written*** appeal to the Purchased/Referred Care Manager.

Address:
LTBB Health Department
ATTN: Elder's Dental Program
1260 Ajijaak Avenue
Petoskey, MI 49770

A fillable appeal form is attached to this application.

Questions?
Call 231-242-1600 (PRC)

LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS

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APPEAL OF DENIAL

PLEASE PRINT YOUR FULL NAME _____ DATE OF BIRTH _____

ADDRESS _____ ENROLLMENT # _____

CITY/STATE/ZIP _____ PHONE # _____

Dear Purchased/Referred Care (PRC) Manager for LTBB,

I have recently received notification from the Health Services Navigator that I have been denied coverage through the Elders Dental Program. However, I believe this decision should be reconsidered for the following reasons:

_____

_____

_____

_____

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_____

In light of the information above, I respectfully request that you reconsider coverage for my services through the Elder's Dental Program. If you have any questions or need further information, please contact me using the information listed above.

Thank you for your attention on this matter.

SIGNATURE _____ DATE _____